C+D

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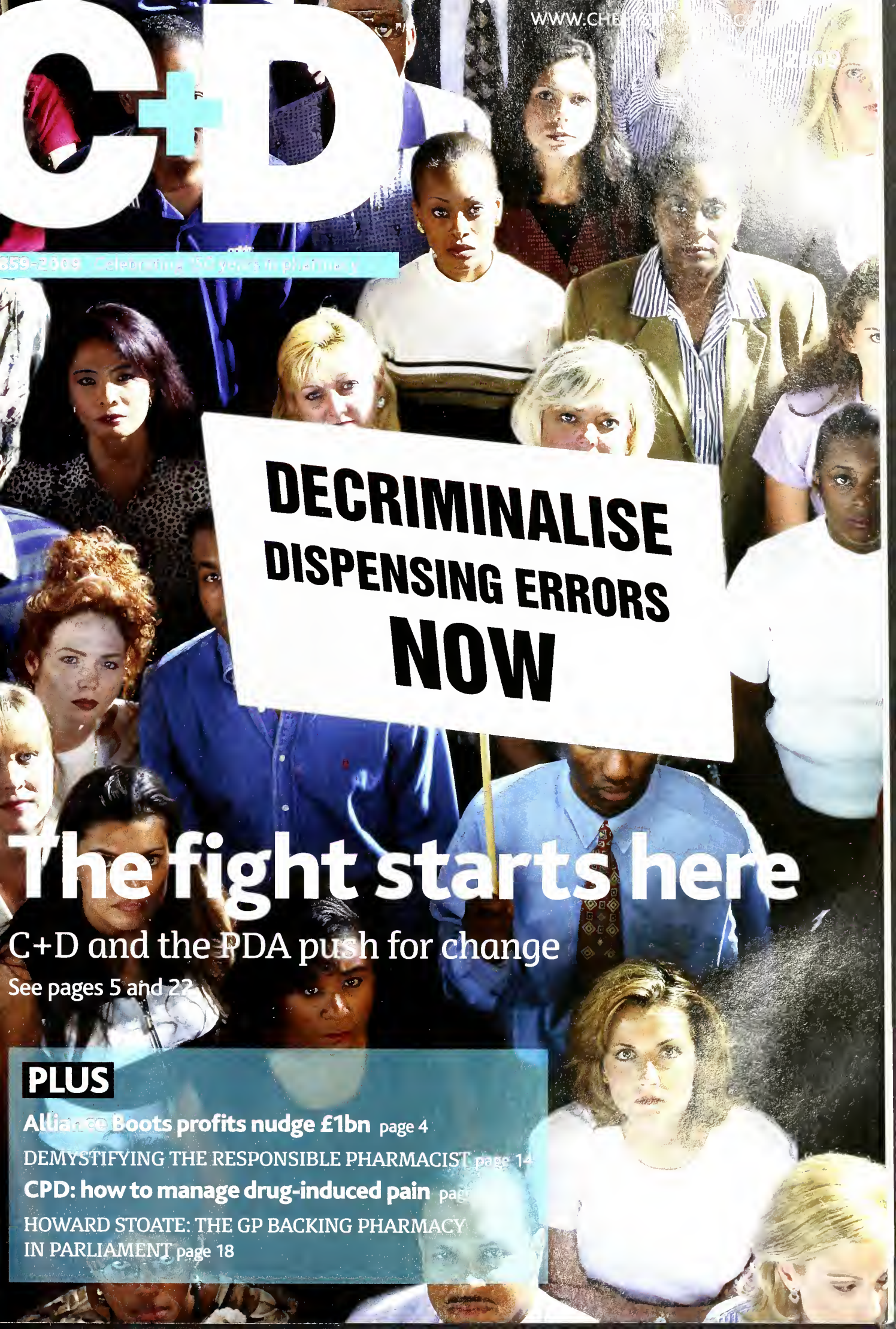
1859-2009 Celebrating 150 years in pharmacy



The fight starts here

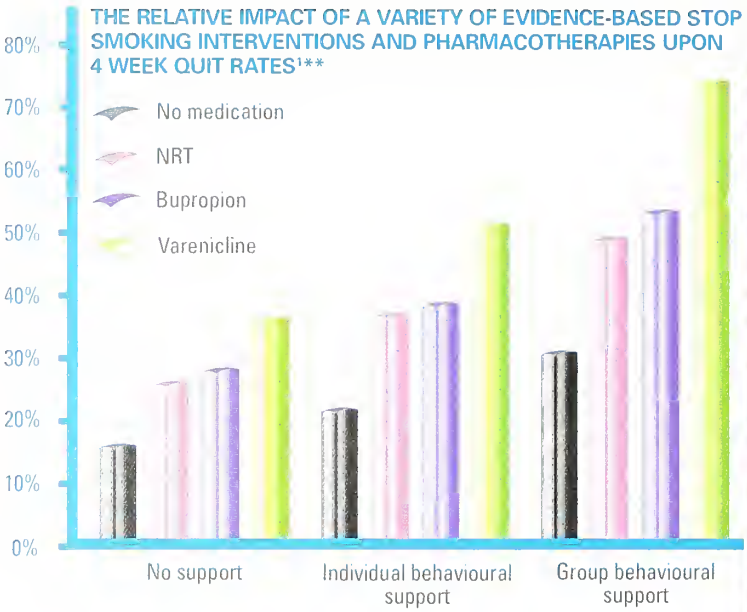
C+D and the PDA push for change

See pages 5 and 22

PLUS

NEW
NHS Stop Smoking Services:
SERVICE AND MONITORING GUIDANCE 2009/10[1]*

- To optimise success all recommended treatments will need to be offered as a first line intervention[1]
- When options are offered to smokers they should be offered with supporting information on the relative chances of success[1]
- These data have been prepared by the authors of this guidance from the Cochrane Reviews by performing indirect comparisons between treatments across different settings. The 4 week quit rates have not been measured directly but have been extrapolated from longer term quit rates[1]



Adapted from the Cochrane Database of Systematic Reviews.

*This is a selection of information from the NHS Stop Smoking Services: Service and Monitoring Guidance 2009/10. The full guidance is available from www.dh.gov.uk/publications.

**Adapted from table 2, page 13 from the NHS Stop Smoking Services: Service and Monitoring Guidance 2009/10.

CHAMPIX – An evidence-based choice in smoking cessation[1-5]

CHAMPIX® Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION – UK. (See Champix Summary of Product Characteristics for full Prescribing Information). Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation**: White, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 1.0" on the other side. **Indications**: Champix is indicated for smoking cessation in adults. **Dosage**: The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8-End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency**: *Mild to moderate renal impairment*: No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events*: Dosing may be reduced to 1 mg once daily. *Severe renal impairment*: 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease*: Treatment is not recommended. **Patients with hepatic impairment and elderly patients**: No dosage adjustment is necessary. **Paediatric patients**: [illegible] recommended in patients below the age of 18 years. **Contraindications**: [illegible] sensitivity to the active substance or to any of the excipients. **Warnings** [illegible] *Effect of smoking cessation*: Stopping smoking may alter [illegible] pharmacodynamic of some medicinal products, for [illegible] may be necessary; examples include theophylline, [illegible] depression, suicidal ideation and behaviour and [illegible] reported in patients attempting to quit smoking [illegible] psychiatric illness. Not all patients had stopped [illegible] symptoms and not all patients had known [illegible] Champix should be discontinued immediately if agitation, depressed mood or changes in behaviour that are of concern for the doctor, the patient, family or caregivers are observed, or if the patient develops suicidal ideation or suicidal behaviour. Depressed mood, rarely including suicidal ideation and suicide attempt, may be a symptom of nicotine withdrawal. In addition, smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). The safety and efficacy of Champix in patients with serious psychiatric illness has not been established. There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation**: Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery**: Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product affects their ability to perform these activities. **Side-Effects**: Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side-effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side-effects were increased appetite, somnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for other less commonly reported side-effects. **Overdose**: Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category**: POM. **Basic NHS cost**: Pack of 25 11 x 0.5 mg and 14 x 1 mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1 mg tablets Card (EU/1/06/360/004) £27.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1 mg tablets HDPE Bottle (EU/1/06/360/002) £54.60, Pack of 56 1 mg tablets Card (EU/1/06/360/005) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder**: Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request**: Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey, KT20 7NS. Last revised: 08/2008.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Pfizer Medical Information on 01304 616161.

For further information, please contact Pfizer Medical Information on 01304 616161 or email medinfo.uk@pfizer.com

References: 1. Department of Health. NHS Stop Smoking Services: Service and Monitoring Guidance 2009/10. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096886. Last accessed March 2009. **2.** Nides M *et al.* Varenicline versus bupropion SR or placebo for smoking cessation: a pooled analysis. Am J Health Behav 2008; 32:664-675. **3.** Gonzales D *et al.* Varenicline, an α4β2 nicotinic acetylcholine receptor partial agonist, vs sustained-release bupropion and placebo for smoking cessation: A randomized controlled trial. JAMA 2006; 296:47-55. **4.** Jorenby DE *et al.* Efficacy of varenicline, an α4β2 nicotinic acetylcholine receptor partial agonist, vs placebo or sustained-release bupropion for smoking cessation: A randomized controlled trial. JAMA 2006; 296:56-63. **5.** Aubin H-J *et al.* Varenicline versus transdermal nicotine patch for smoking cessation: Results from a randomised, open-label trial. Thorax 2008; 63:717-724.

CHAMPIX® varenicline tartrate

[illegible] April 2009 CHA/52

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TABPI Awards 2008
Winner for news coverage

> LEGISLATION SHOULD BE BROUGHT UP TO DATE TO REFLECT THE MODERN WAY HEALTHCARE IS DELIVERED

The campaign to decriminalise dispensing errors starts in earnest today and your support will be vital to its success.

Like every other pharmacist, I can recall my law and ethics lectures at university where we were taught that dispensing errors could lead to a criminal prosecution. But the high profile case of former locum Elizabeth Lee, who last month received a suspended three-month jail sentence, has only served to sharpen the industry's focus on this key issue.

Mrs Lee was charged under the Medicines Act 1968 – but the legislators that drafted the Act clearly did not intend for it to be used as a blunt instrument against pharmacists who unwittingly commit single dispensing errors. Unfortunately that's just how it has transpired in practice.

Community pharmacy in 2009 is worlds apart from that which existed in the late 1960s. Our level of knowledge of human anatomy and drug delivery would be unrecognisable to our counterparts from 40 years ago. It seems only right that legislation is brought up to date to reflect the modern way healthcare is delivered.

The Pharmacists' Defence Association, which represented Mrs Lee, has explicitly set out what it wants to achieve with its latest campaign (p5 and p22): pharmacists should be treated in the same manner as other health professionals and not as some sort of freakish anomaly.

Investigation by professional regulators is the accepted method of scrutiny for all other healthcare professions and pharmacy should be no different. And the emergence of an overarching super regulator, the Council for Healthcare Regulatory Excellence, which oversees the regulators for pharmacists, doctors and nurses among others, and is answerable to parliament, simply adds weight to the argument that pharmacists should be disciplined by their regulator.

As part of the push to free pharmacists from the spectre of criminal prosecution, C+D will gather support from the industry and lobby those in power.

Across the four home countries, devolution has seen the emergence of innovative pharmaceutical services tailored to the needs of local populations. If this transformation is to continue, the threat of a criminal prosecution for a simple dispensing error must be banished once and for all.

The PDA says there are 20,000 errors made in England and Wales every month. Even if this is a gross overestimation, it's only a matter of time before more pharmacists face the same ordeal Elizabeth Lee has endured.

See overleaf for details of how you can support the campaign to decriminalise dispensing errors. With more to follow next week – success will depend on each one of us.

Gary Paragpuri, Editor

Features

Alliance Boots to prioritise investment in existing stores

Group looks ahead as pharmacy business sees dispensing volumes and MURs soar

Jennifer Richardson

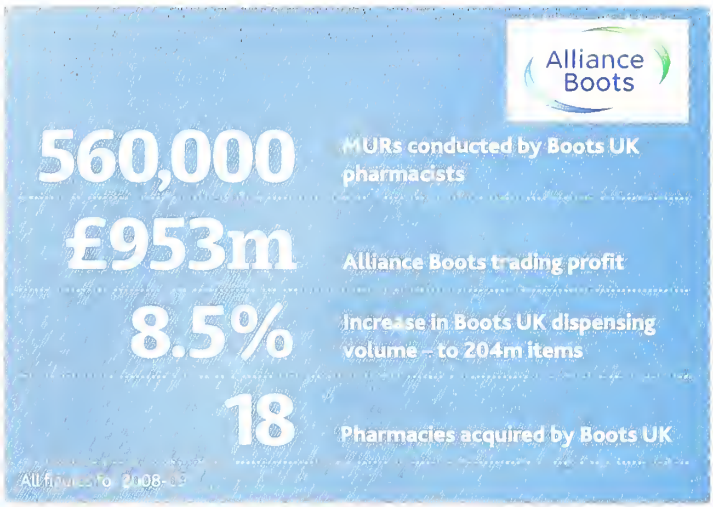
Alliance Boots has pledged to focus UK investment on its existing pharmacies as a priority over expanding the chain.

The commitment from the company's executive chairman came as the pan-European group announced a second consecutive year of double digit growth as a private company. Trading profit for 2008-09 was up almost 12 per cent on the previous financial year, to over £950 million.

AB executive chairman Stefano Pessina said: "We believe that the best way to improve our offer and profit is to invest in the stores that we have."

However, group finance director George Fairweather revealed that Boots UK would be taking over a number of former Woolworths stores, and that it had a "wish list" of additional locations. He did not specify details.

In 2008-09, Boots UK acquired 18 pharmacies and opened 17 new stores containing pharmacies. But two thirds of its investment had gone into existing locations, Mr Pessina said. In addition to the rebranding of 400 stores as 'your local Boots pharmacy', a further 57 branches were refitted.



Boots UK's like-for-like revenue increased by 1.3 per cent, aided by Boots pharmacists significantly increasing their medicines use review output for the second year running, with 560,000 conducted – an increase of over 45 per cent.

Income from this and locally commissioned pharmacy services was still "relatively modest", Alliance Boots said, but had increased by over 30 per cent year on year.

Dispensing volume increased by 8.5 per cent to more than 200 million items, but was offset by lower generic reimbursement prices.

The recruitment of 950 pharmacists throughout the year emphasised Alliance Boots' commitment to UK pharmacy, Mr Fairweather said. He reiterated the company's policy of expanding its in-store GP surgery model (currently in six stores), saying it had "a lot" of projects in the pipeline.

"Over time I'd expect us to have a significant number," he said. "We think it's the way forward."

DTP not a concern, says chief

Direct to pharmacy distribution has not made the UK wholesale market less attractive to Alliance Boots, executive chairman Stefano Pessina has said.

In "the most difficult market conditions" the group's wholesale division had seen across Europe, it posted an increase in 2008-09 trading profit of 4.4 per cent.

These conditions were due in part to "evolving ways in which prescription medicines are supplied to pharmacies", Alliance Boots said in its preliminary annual results this week.

But in the UK, lower revenue from DTP was "more than offset" by Alliance Healthcare being chosen as a supplier in many manufacturers' selected wholesaler deals, the group said. And Mr Pessina told C+D he expected manufacturers to move away from DTP in the future.

"We will have to continue to adapt and to change now [manufacturers] are changing towards the single channel distribution," Mr Pessina said. "In th future, we will probably have to switch back." **JR**

Shrewsbury pensioner Henry Kurek popped into his local Lunt Pharmacy and pharmacist Ruth Jones gave him information about free home fire safety checks into the bargain. The recommendation was part of an innovative partnership between the LPC and fire service. In return for pharmacies promoting their safety checks, firefighters visiting pensioners' homes for the service will provide information on medicines use reviews. Shropshire LPC service development manager Lindsey Fairbrother told C+D: "It's partnership working and that's going to be the way forward for pharmacy." Ms Jones and Mr Kurek are pictured with firefighters Simon Roberts (centre left) and Stuart Dryden

Emergency stocks buffer plan under fire

Pharmacists have spoken out about the worsening stock shortage problem and said a PSNC and British Association of Pharmaceutical Wholesalers plan for wholesalers to keep emergency stock buffers would not go far enough.

But the BAPW defended the plan, telling C+D it "had some mileage" and revealing some manufacturers have already agreed to meet to discuss it next month.

The BAPW and PSNC last week slammed branded medicines quota arrangements as "not sustainable" and asked for emergency stock measures to be put in place.

But Fin McCaul, chair of the Independent Pharmacy Federation, said: "This may alleviate [the problem] but it's not a solution. The only way to solve it is to have price changes across Europe, and that wil take time."

Angus Carmichael, a pharmacist Hawes, North Yorkshire, agreed: "It a step in the right direction but we shouldn't need to have an emergency buffer."

Martin Sawer, executive director of the BAPW, agreed solving the problems would be an ongoing process. He said: "We're not suggesting it's the panacea. What w are trying to suggest is a workable compromise. It's about identifying products which are repeatedly in short supply." **EW**

Fight to decriminalise errors kicks off

CAMPAIGN Sector's support to be used to lobby ministers

What we will do

We will gather support from:
- grassroots community pharmacists – including employees, locums and employers
- other sectors of the profession – hospital pharmacists, academics, and industry
- pharmacy organisations
- fellow healthcare professionals – including doctors and nurses.

We will use this support to lobby:
- MPs and the health ministers in the four home countries
- the four chief pharmacists.

Your support will help the PDA achieve its objectives: to overturn Mrs Lee's conviction; and to amend the 1968 Medicines Act to clarify that it was not intended to criminalise pharmacists for mistakes in the workplace. To read more about the PDA's aims, turn to p22. More details of how you can support C+D's campaign will appear in next week's issue.

Jennifer Richardson and Chris Chapman

DISPENSING JUSTICE

C+D is today launching a campaign to decriminalise dispensing errors, following the suspended jail sentence handed to a pharmacist who made a dispensing mistake.

The Elizabeth Lee case (see details below) has prompted unprecedented unity within community pharmacy, with calls for decriminalisation coming from grassroots individuals, organisations, independents and multiples alike.

C+D will ensure this support is effectively channelled to try to secure a positive outcome for the whole sector, and help the PDA achieve its aims: to overturn Mrs Lee's conviction; and to amend the 1968 Medicines Act to clarify that it was not intended to criminalise pharmacists for mistakes in the workplace. More details of the PDA's campaign can be found on p22.

C+D will ensure the sector's response to the case is directed at those who have the power to implement change.

Support will be gathered from community pharmacists and organisations, other sectors of the profession and fellow healthcare professionals, and used to lobby the chief pharmacists, MPs and health ministers in all four home countries.

The all-party pharmacy group has already urged C+D readers to send their views to contribute to a parliamentary meeting on the issue on June 16. And some MPs have also written to health ministers on behalf of pharmacists clamouring for change.

Lib Dem MPs John Thurso and Annette Brooke have both pledged to write to health ministers on behalf of constituents over the issue.

An online petition to decriminalise dispensing errors has topped 11,500 supporters. Comments posted by signatories slam Mrs Lee's sentence as a "disgrace", while others insist a change in the law is "the only common sense option".

RPSGB will not discipline Lee

The RPSGB has decided not to take disciplinary action against Elizabeth Lee, the pharmacist whose case ignited the sector's demands to decriminalise dispensing errors.

Society registrar Jeremy Holmes granted Mrs Lee's request to leave the register voluntarily on May 8, ending the possibility of disciplinary action by the Society.

The Society said Mr Holmes considered Mrs Lee's plight an "exceptional case" and he had allowed her to leave the register, despite having an outstanding fitness to practise complaint.

Mrs Lee had been on the Society's non-practising register since 2007, after dispensing propranolol instead of prednisolone to a patient who later died. She was given a three-month suspended sentence at the Old Bailey over the mistake, despite the court finding she bore no legal or factual responsibility for the death.

The RPSGB said Mrs Lee's case was "exceptional"

The RPSGB has also confirmed there was no complaint lodged against Tesco, the company Mrs Lee was working for when the error occurred. Her defence team had claimed the dispensing error arose because of "long and arduous shifts" at the pharmacy in Windsor.

The Society confirmed Mrs Lee's fitness to practise had been under scrutiny as a result of the criminal case, and that if she applied to rejoin the register, it would be treated "as any other application", including the disclosure of criminal convictions. **CC**

Central flu plan needed

PSNC has called for greater central NHS co-ordination in pandemic planning. Swine flu had shown some PCTs' planning to be less thorough and robust than needed, said chief executive Sue Sharpe.

C+D Generics Guide

The C+D Generics Guide is now available to subscribers from the C+D Data website. To access the guide, log in at www.cddata.co.uk.

Celesio profit drop

The parent company of Lloydspharmacy and AAH has blamed the weak pound for falling profits. Celesio reported a drop in operating profit of 3.6 per cent to €144.5 million in its 2009-10 first quarter results. Sterling's low value contributed a loss of around €15m, with weaker OTC business also "a burden".

Spam emails

C+D has been made aware of a spam email that fraudulently uses the Chemist+Druggist logo to offer drugs such as Cialis and Viagra from an internet pharmacy. We would like to clarify that this email has not been sent by C+D and our legal advisers are investigating the matter further.

Quality metrics coming

Pharmacy bodies are already working to develop quality metrics for the profession to work to, PSNC has said. The comments came after the DH published a list of more than 200 "quality indicators" to help clinicians improve care. **www.chemistanddruggist.co.uk**

Society call-up possible

The RSPGB has been granted powers by the government to call up "suitably experienced persons" to practise as pharmacists in a national crisis.

Responsible Pharmacist your complete guide
See page 14

Membership numbers 'not critical'

The number of people choosing to join the new professional leadership body next year is "probably not as critical as some people might think", RPSGB President Steve Churton has told C+D.

Mr Churton said the details of internal business plans would not be discussed, but there were several possible models for the body "right the way down to some low [membership] figures".

His comments came after a survey revealed that almost two-thirds of RPSGB members were either undecided or not planning to join the new body next year.

Mr Churton said members deciding not to join would be disappointing from a representation point of view but added: "If I were a start-up organisation, which is what we are viewing this as, I would be delighted if one third of people said they were going to join without knowing what we are going to offer them." **ZS**

Swine flu preparations 'focus on vaccination'

Increased demand for private vaccine is predicted by insiders

Zoe Smeaton

Pharmacists should be involved in vaccination schemes and could see a boost in demand for private flu vaccines this year, industry insiders have said.

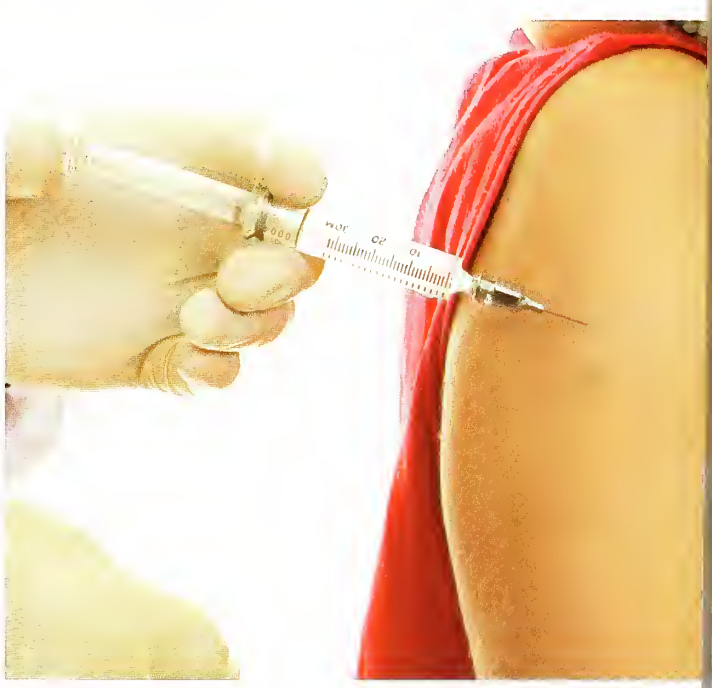
The comments came as efforts to prepare for a possible swine flu pandemic in the UK were stepped up this week.

Alastair Buxton, head of NHS services at PSNC, said it would be a good idea for PCTs to be upskilling pharmacists to administer vaccinations of all kinds to help improve access. He added: "If we can create capacity in the workforce before a [flu] pandemic it would be sensible."

And Ajit Malhi, head of marketing services at AAH, which last year launched a private flu vaccination programme for members to offer, said he thought the recent focus on swine flu would lead to added interest in the private scheme.

He said: "I think we will have a big uptake of the private flu service this year."

The UK has continued with its preparations for a flu pandemic, with the government signing deals with GSK and Baxter to secure supplies of up to 90 million doses of H1N1 flu vaccine. It hopes this will speed production of a pre-pandemic vaccine and provide stocks to protect the most vulnerable people in advance of a possible pandemic.



Pharmacists should be trained to administer vaccinations before a pandemic begins, experts believe

The industry also appears to be moving to safeguard supply of OTC medicines if a pandemic does occur. John Davies, retail services director at Mawdsley-Brooks, told C+D: "We know the generic manufacturers are increasing their production and there is debate about whether that should be [stored] with the manufacturers or the wholesalers."

Is your LPC prepared for a pandemic?

zsmeaton@cmpmedica.com

In brief

Wider use of BP drugs

Drugs to lower blood pressure should be offered to anyone at risk of a heart attack or stroke as they could reduce these events regardless of blood pressure, UK researchers have said.

Heatwave plan updated

The DH has issued updated guidance on coping with heatwaves, suggesting people with respiratory problems should stay inside during the hottest part of the day.

Clueless on vitamin D

Only a third of UK adults know that vitamin D is essential for healthy bones, the National Osteoporosis Society has warned.

C+D Awards 08 honoured

The C+D Awards 08 have been shortlisted in the non-exhibition event of the year category at this year's Association of Event Organisers Awards.

MHRA approval of Arnica pillules sparks row over homeopathy

An MHRA decision to approve a homeopathic medicine sparked a row this week as pharmacists prepared to debate the medicines at the RPSGB branch meeting.

The MHRA move was branded "ridiculous", with some pharmacists pushing to distance the profession from homeopathy. But supporters of homeopathy condemned the critics as being prejudiced.

Nelsons Arnicare Arnica 30c pillules were approved by the MHRA last month under the National Rules Scheme, a programme for licensing homeopathic products. The scheme does not require homeopathic therapies to have rigorous clinical data.

But the decision was slammed by Dr Angela Alexander, senior clinical lecturer in pharmacy at the University of Reading. She said: "It's ridiculous really that you can claim therapeutic index without having to demonstrate efficacy."

The comment came as the Slough and District RPSGB branch prepared to put forward a motion to stop homeopathy being promoted in pharmacies at the Society branch representatives meeting this week.

The branch said: "Registration as a pharmacist and practice as a homeopath are not compatible."

But the motion was condemned by London pharmacist and homeopath Tony Pinkus, who said it was "not based on anything other than prejudice as far as I can gather". **CC**

For more on the RPSGB branch meeting see next week's C+D

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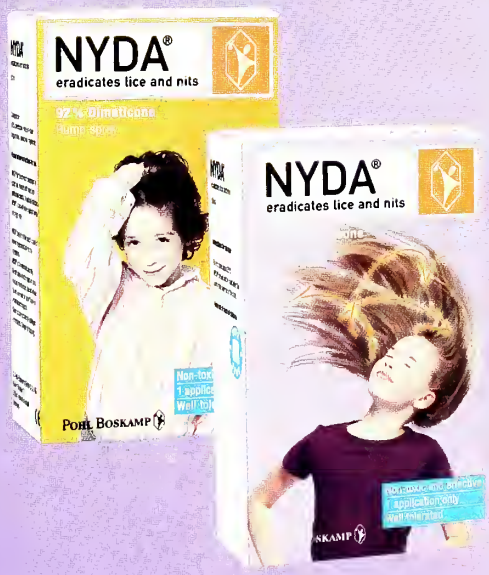

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References: 1. Oliveira F.A.S. et al.: High *in vitro* efficacy of NYDA® [illegible] pediculicide containing dimeticone [illegible]
3. Heukelbach J. et al.: "A highly efficacious pediculicide based on dimeticone 92% optimized observer-blinded, parallel-group [illegible]

Dispensary talk

How should 30-day emergency supplies be paid for?

"At the moment we do emergency supply for five days and we don't charge people, so I wouldn't be looking to charge with 30 days. But I would expect the government to completely reimburse us."
David Badham, Stewart Pharmacy, Evesham, Worcs

"At the moment it depends on the patient. If we know them and we do their prescriptions every month we don't ask them to pay and I think that will stay the same. This is really going to be aimed at people who can't get out, so the elderly, and they're the people we run a prescription collection service for anyway."
Shirley Cox, Assura Pharmacy, West Everton, Liverpool

Web verdict

Through the NHS 13%

Pharmacists should fill in a form similar to an FP10 36%

Patients should have to pay 51%

Armchair view: The sector is unsure who should pay for emergency supplies, with half of respondents expecting patients to cough up for their medication.

Next week's question:
Does homeopathy belong in pharmacy? Place your vote at **www.chemistanddruggist.co.uk**

Calls for funding to cope with RP absences

Second pharmacist needed to ensure safety is maintained

Zoe Smeaton

Pressure has been mounting for the government to provide funds for a second pharmacist to be available in all dispensaries to ensure safety under the responsible pharmacist legislation.

The new rules will apply from October and allow responsible pharmacists to be absent from the pharmacy for up to two hours a day.

But second pharmacists should be available to stay in the dispensary during those absences to ensure safety, says the Northamptonshire RPSGB branch and the Pharmacists' Defence Association.

The branch is calling on the RPSGB to lobby for funding for second pharmacists, and their motion was due to be discussed at the Society's branch representatives meeting as C+D went to press.

David Wildman, chair of the branch, said he was concerned that the absence rules could be used to cut down on pharmacy cover generally. He said he hoped the sector could secure funding to have a second pharmacist to work on a part time basis, perhaps providing additional clinical services.

RPSGB should lobby for funding for second pharmacists, says members

John Murphy, director of the Pharmacists' Defence Association, agreed it would be safer to have a pharmacist on the premises at all times to "be watchful" in the absence of the responsible pharmacist. He supported the branch's sentiments.

The Northamptonshire motion is one of several up for debate at the branch meeting, where other topics to be covered include homeopathy and child protection awareness.

The Society is also holding its annual general meeting this week, although no motions have been raised for this.

Responsible pharmacist tools

C+D is this week launching a full guide to the responsible pharmacist legislation, which comes into force in October, in association with the NPA and supported by McNeil Products Ltd.

Look out for the first of a 10-part series of columns on p14, and see more information at www.responsiblepharmacist.com

More red tape from technician register

Legislative changes giving the RPSGB powers to regulate pharmacy technicians from July will lead to yet more administrative burden for the profession, the Independent Pharmacy Federation (IPF) has warned.

The rules, which will affect technicians in England, Scotland and Wales, recognise pharmacy technicians as a statutory profession. This means technicians will have to register with pharmacy's regulatory body to practise in the UK and they must then pay fees to stay on the register.

The Society said contractors should be aware of the changes as they would need to check the qualifications of their dispensing staff and consider whether registration would be appropriate.

But this would increase the burden on a sector already adapting to new regulations and reforms, warned IPF chairman Fin McCaul.

Mr McCaul explained: "It's good that we have got technician regulation and registration. But the challenges are more red tape, more hoops to jump through, in a system struggling to cope."

Although the Society will hold a register of technicians from July 1, current support staff will have a two-year 'grandparenting' window to sign up. After then 'pharmacy technician' will be a restricted title.

The Society has produced guidance for those wanting to join the register, and further information on what the technician changes mean for pharmacy can be seen at www.chemistanddruggist.co.uk. **CC**

Brit film nears completion

The makers of British film The Pharmacist, which pharmacists hope will be good PR for the profession, say they should have completed their work by August.

Producer Tom Dalton told C+D the team was currently working on the technical processes such as the soundtrack and special effects. He said: "We're chugging away and we're getting closer every day."

Mr Dalton said a pharmacist had attended a screening of an early version and had been amused to see the pharmacist in the film having problems with her PCT. While the film was not taking a particularly political angle, Mr Dalton said he was pleased that the coverage they had included on pharmacists' politics seemed honest.

He added that early feedback had "renewed the team's confidence" in the film. **ZS**

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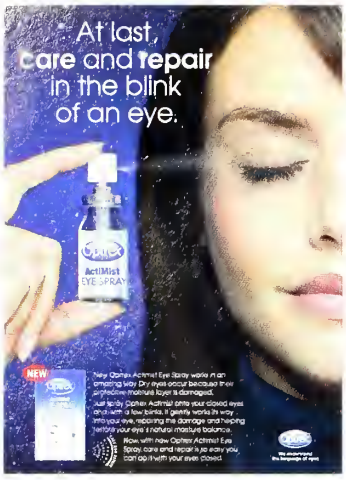
Optrex Actimist is in the public eye

Optrex Actimist will be supported by a summer advertising burst as part of a £1.5 million marketing campaign for the premium priced eye spray (£14.67/10ml).

The product, which is sprayed directly onto closed eyelids, will appear on TV and in digital and print advertising and promotions from June 1 until the end of July.

When Optrex Actimist was advertised on TV for the first time in March, the product had a sales lift of over 600 per cent, according to Reckitt Benckiser. The company said that stocks in many outlets ran out within days and this meant it found itself unable to satisfy all its orders for several weeks.

"Even we were surprised by the scale and speed of take up and were unable to keep up with demand," said Camillo Pane, general manager of RB Healthcare UK, who believes



the spray for dry eye sufferers has captured consumers' interest. Production of the product has since been stepped up to meet demand.

Reckitt Benckiser
Tel: 01482 326151

Summer boost for Vagisil

Combe International aims to boost sales of its Vagisil intimate feminine care range this summer with national TV advertising throughout June.

The campaign will focus on Vagisil Medicated Créme, which is an anaesthetic cream formulated to give relief from all kinds of feminine itching, burning and irritation, including external thrush itching.

Combe is investing a total of £1 million in advertising the brand in 2009 and the TV campaign will be back on air again later this year.

Combe International
Tel: 0208 680 2711
www.vagisil.co.uk

Evian spray keeps its cool

Kent Cosmetics is relaunching its Evian Brumisateur Face Mist with a fresh new look.

The facial spray has been repackaged in a stylish new white and pink container, which has already won a packaging award.

The natural cooling mist is designed to moisturise, refresh and tones all skin types and has properties identical to the Evian natural mineral water.

Kent Cosmetics claims regular use of the product can increase skin hydration by 14 per cent.

It can be used to 'fix' make-up or as a cooling treatment for burns and abrasion. It may also be useful to cool and hydrate during pregnancy and when giving birth.

Price: £3.50/50ml; £6.95/150ml; £8.95/300ml
Pip codes: see C+D Monthly Price List or www.cddata.co.uk
Kent Cosmetics
Tel: 01622 859898

Mask gears up for swine flu

The Covaflu FFP3 face mask has been repackaged to show that it can be used for all pandemic flu situations.

The mask has a filtering facepiece to provide a high level of filtering capability and face fit and a barrier to both droplets and fine aerosols. It is CE marked and meets the European Standard class FFP3.

"Masks with FFP3 respirators will block more than 99 per cent of airborne virus droplets that are 0.3 microns in size – the majority of swine flu-infected droplets will be larger than this," said Clinova.

The company has seen a surge in demand for the mask in the past weeks and has stepped up production to meet demand.

A new dispenser pack of 10 masks can be used as a counter display unit. The mask is now available from AAH Pharmaceuticals and Alliance Healthcare.

Price and pip code: £6.79, 325-2699
Clinova
Tel: 08456 521829
www.clinova.co.uk

Nelsons gets on-pack approval

Nelsons has received approval from the Medicines and Healthcare products Regulatory Agency (MHRA) to allow label indications on its best-selling Clikpak Arnicare Arnica 30c pillules.

The product can now carry the on-pack indications: "A homeopathic medicinal product used within the homeopathic tradition for the symptomatic relief of sprains, muscular aches and bruising or swelling after contusions."

The decision comes as a result of a new scheme to allow the inclusion of therapeutic indications on the packaging of homeopathic medicines, which is being implemented in the UK by the MHRA.

Nelsons said it is the first company to have approved on-pack indications under the scheme and other Clikpak products soon to go through the process of gaining licensing are for first aid, aches and pains, skin, colds and flu, women's health and digestion.

Nelsons; tel: 0800 289515

New ear-a for Cerumol campaign

To celebrate its recent acquisition of Cerumol, Thornton & Ross recently commissioned a dramatic trade advertisement (C+D May 9, p7) featuring pictures of the ears of many of its Huddersfield-based employees.

The 'Trusted by millions of ears for over 50 years' advert shows an enlarged image of an ear and, on closer inspection, it can be seen that the ear is composed of hundreds of tiny ear images.

Thornton & Ross is offering a free coffee maker (worth up to £100) to the pharmacy that most accurately guesses the number of different ears featured in the advertisement.

To enter the competition, send your answer and your contact details to Cerumol@thorntonross.com by July 31. The competition is open to UK pharmacy employees aged over 18. The winner will be notified by August 31.

Thornton & Ross
Tel: 01484 842217
www.thorntonross.com

Dry eye relief

From June 1, Systane Lubricating Eye Drops will be available on prescription.

The eye drops are formulated to provide long lasting relief from dry eye, particularly morning and end of day dryness.

The product contains a polymer system designed to work as soon as a drop comes into contact with the eye. On contact with tears, the liquid drop turns into a thin protective gel layer that binds to the ocular surface.

The drops are available in convenient preservative-free single dose vials, as well as the original 10ml multidose, which may be used up to six months after opening.

Adult dose is one or two drops as required.

Pip codes: **single dose 041-4052; multidose 303-8965**
Alcon (UK); tel: 0800 092 4567

Stérimar is now on prescription

Both formulations of Stérimar sea water nasal spray are now available on FP10 (50ml) as well as OTC.

Stérimar Isotonic Nasal Hygiene is a natural formula for hayfever, allergies, colds, rhinitis, sinusitis, rhinopharyngitis and nasal cleansing. It can be used in conjunction with anti-histamines, antibiotics, decongestants or corticosteroids and is suitable for babies from three months and pregnant women.

Stérimar Hypertonic Blocked Nose has a stronger decongestant effect because it has a higher salt concentration and is for severe congestion, blocked noses, rhinosinusitis and chronic sinusitis. It contains copper and manganese for their anti-infective and anti-allergic properties and is suitable for adults and children aged three years and over.

Pip codes: **Isotonic Nasal Hygiene/ 50ml 345-6688 Hypertonic Blocked Nose/50ml 345-6696**
Church & Dwight; tel: 01303 858700

Pandemic will expose supply problems

> PENSIONERS WOULD RATHER DIE FROM NOT TAKING THEIR MEDICATION THAN PAY FOR THEIR DRUGS

A flu pandemic could finally force those in power to take seriously the problems blighting the profession. If community pharmacy collapses during a pandemic, the consequences don't bear thinking about.

If the government thinks extending the emergency supply legislation to 30 days will solve any problems, they really have got their head in the clouds.

There are countless drugs that I can't get one day's supply of at the moment, so a change in the rules could prove academic. And many pensioners would rather die from not taking their medication than pay for their drugs.

Workload concerns have largely been ignored – well wait until a few pharmacies close. It will literally be impossible to dispense the majority of prescriptions with insufficient staff and pharmacies working in clusters. That hour a day wasted chasing supply problems will suddenly be brought into stark relief. Oh, and don't be surprised that there aren't any 'spare' pharmacists on the register to take up the slack.

Responsible pharmacist regulations will have come into force just in time to be exposed as the pointless exercise they are. Few pharmacists, registered or not, will volunteer to be the responsible pharmacist in a place with insufficient trained staff, meaningless SOPs, stock shortages and no proper support from anyone. It could be as simple as this: stay at home and avoid the flu, or go to work, be responsible for a number of deaths and get sent to prison for your efforts.

Safety of pharmacy staff has been an issue for some time but they could become targets for many scared and frustrated patients. Would the government finally take notice of the dangerous conditions in pharmacies if a few staff were killed in rioting?

Amid all the supply chain chaos, my wholesaler has the cheek to write to me, urging me to do something about a DTP scheme from which it's excluded. It says the deal might not suit me. Well let me tell you that I'm not convinced that any of the new distribution deals have been that helpful.

And when the 13th scheme takes effect this summer, some pharmacies will receive at least six deliveries a day simply to maintain stock levels. A flu pandemic will expose this system for the painful waste of time and effort that it is.

PSNC blaming pharmacists for their supposed role in the stock shortages because a few are legally exporting medicines is simply distracting from the real issue. As is its proposal for ring fenced emergency stock (C+D, May 16, p4).

There is just not enough stock of some products in the supply chain – well certainly not at my pharmacy. Manufacturers need to ramp up their production, and quick. Roche's production of millions of doses of Tamiflu at short notice is proof that it can be done.

Conspiracy theory undermines

Nowadays it is very easy to contact a member of Parliament and as a consequence I become aware of a number of conspiracy theories. These range from the well known ones, such as the twin tower collapse was a George Bush plot, to the rather more parochial "the council refused my planning application because I complained about my bins!".

That sort of stuff is all meat and drink to the average politician but I must admit to some surprise when I heard there were conspiracy theories surrounding the All Party Pharmacy Group. According to the theorists, the group is some sort of front for the bodies who fund it. Hmmm – let's examine the evidence.

It is no secret that the group is funded by contributions from the RPSGB, NPA, PSNC and the CCA. As those four organisations rarely have a completely joined up view (although I am pleased that things are improving in that direction) it is hard to see what the influence could be.

However, the group recently organised a series of lunches between health spokespeople and the four organisations that were very joined up. The parliamentarians who attended greatly appreciated the opportunity to learn more about pharmacy.

Sometimes suggestions for meetings are put forward to officers of the group, but ultimately we have the final call. It was Howard Stoate's idea to undertake the enquiry, which informed the white paper, and recently we both decided that a meeting on issues surrounding Elizabeth Lee would be a good idea. Within 10 minutes of agreeing the meeting, the room was booked and knowledge of the meeting was in the public domain. That wouldn't have happened if we had to run things past the paymasters.

The public are very cynical about how politicians are influenced but the vast majority of MPs are fiercely independent and have questioning minds.

Of course, conspiracy theories are always much more interesting than reality, which is why they gain prominence. They are also, unfortunately, a complete waste of time and energy.

At a time when we should be united in making the white paper a reality and putting some of the good ideas into practice, it seems a shame that others in the profession seek to undermine the role the all party group can play.

Sandra Gidley, Lib Dem MP and shadow health spokesperson

> CONSPIRACY THEORIES ARE ALWAYS MUCH MORE INTERESTIN THAN REALITY

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The Responsible Pharmacist

Across the UK, the profession must start getting to grips with the Responsible Pharmacist regulations before October 1. In the coming months C+D and the NPA, supported by McNeil Products Ltd, will be bringing you all the tools and advice you need to prepare for the legislation. Here, in the first of a 10-part guide to the legislation, C+D and the NPA explain what is going on.

PART 1: Responsible pharmacist, irresponsible pharmacist, or just a pharmacist?

Like many other pharmacists, you may have been pushing these questions and others to the back of your mind until the new Responsible Pharmacist legislation comes into force.

Replacing the existing concept of personal control from October 1, the new rules state that every pharmacy must have a responsible pharmacist who is legally responsible for the safe and effective running of that pharmacy.

But the laws bring in new requirements for the entire profession. Locums and employees may find themselves assessing pharmacy procedures more closely and having to decide whether or not they want to take on the role of a responsible pharmacist. And superintendents and owners will need to ensure that effective procedures and systems are in place to allow their pharmacists to comply with the law.

There are some tough issues to grapple with, such as how and when you might want to be absent from the pharmacy and where accountability might lie in the case of errors. And there will be some immediate changes across the UK, starting with a requirement to keep a record of who was the responsible pharmacist at any given time.

So if you haven't already, it's time to start getting both yourself and your pharmacy prepared to ensure you are not caught out.

There is lots of potential for confusion, but C+D and the NPA have teamed up to give you over the coming months the facts, tools and advice needed to make sure you manage the law changes with ease. Look out for more advice in the columns, which will be published every two weeks in C+D.

PART 2: What do you need to do and when? See the next column in C+D, June 6.

Take home points

- The Responsible Pharmacist (RP) legislation comes into force across the UK on October 1 and replaces the concept of personal control
- To keep you up to speed, C+D and the NPA will provide you with a range of tools, guidance and case studies on RP in the coming weeks. These include:
1. A fortnightly RP column in C+D that will explain all of the changes
2. A handy practical guide written by Prof Joy Wingfield demystifying the new rules.
3. A dedicated website at www.responsiblepharmacist.com which will host resident RP expert – the NPA's Michelle Stylee – to answer queries.
4. Nineteen SOPs to download and personalise.
- Don't miss any of the RP tools – sign up to C+D's weekly e-bulletins at www.chemistanddruggist.co.uk/register to have the information sent to your inbox for free

The C+D and NPA Responsible Pharmacist Toolkit is supported by McNeil Products Ltd

23.05.09

Features

Update

Your weekly CPD revision guide

Module 1478

Drug-induced pain disorders

A number of POMs can cause pain as a side effect. This guide looks at the mechanisms of their action and how best this can be managed

60-second summary

Which drugs can cause pain as a side effect?

Statins can cause muscular pain, diuretics may cause cramps, vaccines and quinolone antibiotics can cause joint pain, long-term corticosteroids can cause bone pain through osteoporosis, opioids may result from both use and withdrawal of strong analgesics.

What increases the risk of statin-induced myopathy?

Drugs inhibiting cytochrome P450 3A4, grapefruit juice (with some statins), alcohol, old age, reduced kidney or liver function, diabetes and hypothyroidism.

This article (Module 1478) can be worth the following CPD competencies: G1a, G1c, G1d, G1e, G1c, G1j, G1j
See http://tinyurl.com/68o7b

The Update April winners D Nukumar Parekh, Hall Green, Birmingham

Professor Janet Krska

Pain is a common symptom presenting in the pharmacy and the most common symptom for which patients consult GPs. In 2007 more than £350 million was spent on oral analgesics and over 50 million prescription items were dispensed. Muscular problems, bone and joint problems and headache present most frequently.

Muscular pain

Most muscular aches or pains are due to generalised wear, overuse, strain or trauma. However, drug-related causes should not be overlooked. Obviously a history is important in helping to determine the cause, but if there is no apparent primary cause or pre-existing diagnosis such as osteoarthritis, medicines should be considered.

Drug-induced muscle disorders can be relatively minor or can progress to serious problems, leading to disability and death (see table 1 online at www.chemistanddruggist.co.uk/update). The most common cause is statins, because they are so extensively prescribed. However, other drugs used in hyperlipidaemia also cause myopathy.

Statin-induced myopathy

In clinical trials the incidence of myopathy is between 0.1 and 0.2 per cent, and that of mild muscle pain is between 2 and 7 per cent. The onset varies from a few weeks to over two years after starting treatment and the severity ranges from mild aches to severe pain, causing reduced mobility. It is dose-related.

The mechanism of statin-induced myopathy is unclear, but may relate to inhibition of ATP leading to cell damage and ultimately cell death. Myopathy can progress to rhabdomyolysis, in which muscle cell walls are disrupted and the contents leak into the systemic circulation. Creatinine phosphokinase (CPK) is an enzyme present in skeletal and cardiac muscle cells so, when either is damaged, blood levels of this enzyme rise, although myopathy can be experienced despite normal CPK levels. CPK should be measured before initiating statin therapy in the elderly or those at risk of myopathy, and when patients present with symptoms.

In rhabdomyolysis, myoglobin released from muscle cells turns urine dark brown. This is usually accompanied by CPK levels of at least 10 times the normal value. Rhabdomyolysis can be fatal, but is not always accompanied by muscle pain. Fatal rhabdomyolysis occurs at rates of less than one per million prescriptions in the USA, although cerivastatin, withdrawn in 2001, carried a higher risk.

The risk of muscle problems is affected by patient factors, other drugs being taken and statin pharmacokinetics. Simvastatin and atorvastatin, the most widely prescribed, are both lipophilic and metabolised by cytochrome P450 3A4. Drugs inhibiting this enzyme increase statin blood levels, increasing the risk of muscle problems (see table 2 online www.chemistanddruggist.co.uk/update). Grapefruit juice can also increase blood levels of some statins. A high alcohol intake increases the risk of myopathy, so this should be queried when starting statins or investigating potential ADRs. Older people, those with reduced renal function or liver function, diabetes or hypothyroidism are also at greater risk of statin-induced myopathy.

Symptomatic treatment

Patients presenting with suspected statin-related muscle pain should be referred for measurement of CPK levels. If elevated (at least five times the normal upper limit), the statin should be stopped. If symptoms are affecting daily life, it may be

necessary to withdraw the drug, regardless of the CPK level.

The dose prescribed should be the minimum effective for achieving target lipid levels. Reduction may resolve symptoms. However, patients should appreciate the need to monitor muscular symptoms regardless of dose changes, because of possible progression to rhabdomyolysis. If the latter is suspected, the patient should be referred and the statin withdrawn immediately.

Cramps

Diuretics are commonly implicated in muscle cramps, because of their effect on electrolytes. Cramps can occur during exercise or at rest, particularly in the elderly and people with reduced peripheral circulation.

Symptomatic treatment

Cramps are notoriously difficult to treat and, if severe, require referral. It is worth checking the serum electrolytes of patients taking diuretics and investigating the possibility of dose reduction or alternative therapies

Bone pain

Drugs can contribute to skeletal problems in various ways. Usually this follows long-term use, but some problems are more acute. Pain can arise from osteoporosis or osteomalacia, both of which can result in fractures following apparent minor trauma (see table 1 online at www.chemistanddruggist.co.uk/update).

Corticosteroids are the most common drug-related cause of osteoporosis and may cause fractures in up to 50 per cent of patients taking them long-term. They decrease osteoblast activity, reduce absorption of calcium and increase its excretion. Osteoporosis is related to the dose and duration of treatment, and fracture risk declines rapidly after stopping the steroid. Long-term heparin is associated with osteoporosis, if given in doses above 15,000 units per day for over three months.

Loss of bone can arise through osteomalacia resulting from lack of vitamin D, precipitated by anti-epileptic drugs, notably those that induce cytochrome P450 enzymes and thereby increase vitamin D metabolism. Long-term aluminium salts can result in osteomalacia by inhibiting bone mineralisation. It is most commonly associated with aluminium use in renal failure, but there have been reports of osteomalacia in patients taking long-term aluminium-containing antacids and sucralfate for peptic ulcer disease.

Symptomatic treatment

Pharmacists should ensure that patients taking oral or high-dose inhaled corticosteroids long-term have been assessed for osteoporosis prophylaxis, following relevant guidelines. Lifestyle advice should be offered, including the need for regular weight-bearing exercise, adequate dietary calcium intake, avoidance of excessive alcohol and stopping smoking.

Pain arising from osteoporosis or osteomalacia is managed similarly to the pain of osteoarthritis, using analgesics and NSAIDs.

Joint pain

Drug-induced joint pain or arthralgia, including gout, is uncommon, but can be caused by a variety of medicines. Vaccines, in particular rubella, MMR, BCG and hepatitis B, have been linked to both acute and longer term joint symptoms. MMR can cause pain in both joints and muscles. Arthralgia after MMR is commonest in adult women, up to 20 per cent, and can persist for several months. It is much less common in children, up to 3 per cent, and of short duration.

All quinolone antibiotics have been reported to cause joint pain, but the mechanism is unknown. It is most common in children and adolescents, so these drugs should be avoided in young people where possible. Symptoms such as stiffness, pain or swelling have been reported, but should resolve on stopping treatment.

Gout, caused by increased uric acid levels, can be precipitated by thiazide and loop diuretics. Unlike primary gout, it occurs equally in both men and women, and acute attacks are rare. It is associated with renal impairment, also exacerbated by diuretics, and pre-existing osteoarthritis.

Ciclosporin raises uric acid levels in up to 50 per cent of patients, often causing symptoms and requiring prophylaxis.

Studies have shown that aspirin, even at the low doses used in CHD prophylaxis, can cause reduced uric acid excretion, particularly in the elderly. However, while it may be wise for patients with a history of gout to avoid low-dose aspirin, there is no evidence that aspirin causes gout.

Symptomatic treatment

Arthralgia should be treated with simple analgesia or NSAIDs. Stopping the diuretic in secondary gout usually relieves the problem, reducing the need for symptomatic treatment. The lowest dose of diuretics should always be used to minimise adverse effects on electrolytes and uric acid. In most patients allopurinol prophylaxis is not required.

Tendonitis

Inflammation of one or more tendons, most commonly the Achilles tendon, is a rare ADR that can lead to tendon rupture. With quinolones, it can occur after the first dose or be delayed for up to six months. Elderly patients and those taking corticosteroids are at increased risk. With statins, there may be increased risks arising from drug interactions similar to those seen with myopathy. It most often occurs within the first year of treatment.

Symptomatic treatment

The causative drug should be stopped if tendonitis is suspected and the relevant tendon immobilised. The ADR must be recorded to ensure the patient does not receive further treatment with drugs in the class.

Headache

Headache may be drug-related in up to 8 per cent of cases. Vasodilators used for angina frequently cause headache, often after the first dose. SSRIs are a common cause of headache, occurring in up to 10 per cent of patients, which may reduce on continued use. Headache is also a common withdrawal symptom from SSRIs.

Although uncommon, medication overuse headache (MOH) can arise from excessive self-medication with prescribed or OTC analgesics. It can occur with opioids, triptans or compound analgesics. Products containing caffeine or the overuse of caffeine-containing drinks may also be implicated. Discontinuing the offending product results in rebound headache, reinforcing the behaviour. Other withdrawal symptoms may occur, such as nausea, agitation and sleep disturbances.

Symptomatic treatment

Tolerance usually develops to headaches caused by vasodilators and SSRIs, but some patients find them severe and are unable to continue treatment. Management of MOH involves gradual withdrawal and supportive treatment with other drugs to minimise withdrawal symptoms, such as NSAIDs or antidepressants. Overuse is also associated with chronic pain many years later. Patients who frequently buy OTC products present an opportunity for pharmacists to identify and manage MOH, and advise on appropriate use of analgesics.

Janet Krska is professor of pharmacy practice at Liverpool John Moores University.

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NEXT WEEK'S UPDATE:
MURs for patients with osteo- and rheumatoid arthritis

Drug-induced pain disorders – recording your CPD

Reflect

Why might steroids cause bone pain? Who is most at risk of tendonitis from quinolone antibiotics?

Plan

This article discusses drugs that can cause pain as an adverse reaction and what you might do about it.

Act

Read the full article online at **www.chemistanddruggist.co.uk/update**.

Read previous articles by the same author if you have not already done so: Reporting ADRs (C+D, February 14, at **http://tinyurl.com/aubtue**) and Drugs affecting the GI tract (C+D, March 28, at **http://tinyurl.com/d8s2rn**).

Read the GP Notebook website on myalgia associated with statins: **http://tinyurl.com/cmvy2y**.

Revise the RPSGB guidance on OTC statins at **http://tinyurl.com/d5yzp7**.

Update your knowledge of medication overuse headaches on **www.patient.co.uk/showdoc/40025928**.

Could you change your questioning of patients asking for pain relief to help identify ADRs? How could you use this information when carrying out MURs?

The CPPE has a programme on ADRs at **www.cppe.ac.uk**

Evaluate

Do you know which drugs may cause pain as an ADR and how you might resolve the problem? How would you advise a patient with pain that may be an ADR?

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Practical Approach

A cardiovascular check

Mrs Louise Jann, a 63-year-old regular patient, has come to the Update Pharmacy to collect her repeat prescription for atenolol 50mg and enalapril 20mg daily for hypertension. Before dispensing it, pharmacist David Spencer makes his usual check.

"How have you been since you picked up the last prescription two months ago?" David asks. "No problems I hope?"

"I've been absolutely fine," Mrs Jann replies. "I've been on these medicines for two years now and I've never felt better."

"So your blood pressure is under control?"

"I suppose so," says Mrs Jann.

"Aren't you sure then? Have you had it checked lately?"

"No, should I have? Anyway, as I said, I feel absolutely fine."

"Don't you have regular blood pressure and cholesterol checks at the surgery? GPs are supposed to do that." David says.

"No, I've never been asked. I just send my repeat prescription request form by post every six months and the surgery mails the prescription back to me."

David replies: "That's a bit odd, maybe you've slipped through the net somehow. Anyway, now you're here I could check your blood pressure for you if you want me to. We're part of a 'Heart MOT' scheme that the local primary care trust is running."

Mrs Jann agrees and David checks her BP. It is 180/70mmHg.

David says: "Your blood pressure is rather high, Mrs Jann. I'm going to refer you to your GP for a further check and I'll make some suggestions as to how we could bring your blood pressure down."

Questions

1. What should Mrs Jann's target BP be?

2. Why might her BP be so high?

3. What could David suggest to the GP?

4. What lifestyle modifications have been shown to help reduce BP?

Answers

1. ≤ 140/85mmHg.

2. She has isolated systolic hypertension and her current therapy may be ineffective.

3. Older patients generally respond better to thiazides or calcium channel blockers than to beta-blockers. David could suggest replacing atenolol with bendroflumethiazide 2.5mg in the morning or with a calcium channel blocker. Mrs Jann's BP should be taken after six weeks on the new regime to check if the target has been achieved. It may also be advisable for Mrs Jann to be prescribed additional antiplatelet therapy – aspirin 75mg daily – once her BP has been reduced to less than 150/90. She should be advised not to take any other medicines containing aspirin.

4. Reduce weight if obese to a target BMI of 20-25; a reduction of 10kg can lower BP by 10-20mmHg. Reduce alcohol intake to no more than three units per day for men and two for women. Undertake regular physical exercise such as brisk walking, aerobics, swimming or cycling for 30 minutes or more on at least three days per week. Reduce sodium intake by not adding salt to food and avoiding processed foods high in salt.

G1a, G1c, G1d, G1q, C1a, C1b, C1c, C2c.

See **http://tinyurl.com/68ox7b**

Meet Howard Stoate, practising GP and champion of all things pharmacy in Parliament. **Max Gosney** went to Westminster to meet a most unlikely ally

Friends in high places

If human cloning should ever become the norm then Howard Stoate's DNA will be highly sought after in pharmacy circles. He's an influential MP, a practising GP and, believe it or not, an ardent pharmaphile.

Dr Stoate has been banging the drum for the pharmacy sector in the corridors of power since being elected in 1997. He launched the All Party Parliamentary Group for Pharmacy (APPG), which gives industry issues airtime at Westminster, and was also the engine behind the recent government white paper dedicated to the profession.

Dr Stoate's enthusiasm is rooted in his days as a trainee doctor. "My GP mentor had a lot of time for pharmacists," he explains. "I went to spend days with my local pharmacist and I thought this guy has something to offer."

Those formative days were to have a defining effect on Dr Stoate's NHS outlook. "In the 1980s we had pharmacists down as people who take packets off shelves and mix potions. I saw they had a lot more to offer and needed to be integrated into mainstream delivery of care," he says.

Nearly 20 years later and he has the platform to push forward those changes. Dr Stoate arrived in parliament as MP for Dartford in Labour's landslide election win of 1997. He set to work immediately. "I started asking around about whether there was any representation in the house for pharmacy. I was told there was nobody, so I went to the president of the Royal Pharmaceutical Society and asked about setting up a pharmacy steering group."

The APPG was subsequently born, at last giving the sector an official voice in parliament after 150 years. The group, chaired by Dr Stoate, brings together MPs, industry leaders and 'ordinary' pharmacists to discuss prevalent pharmacy issues. Its crowning glory so far has been a 2007 report into the future of pharmacy that, says Dr Stoate, was the blueprint for the pharmacy white paper.

"I think we've been very influential in helping the DH come up with pharmacy policy. Our report had a huge influence on the white paper. We hadn't realised how interested the DH was, so

maybe we could have chucked more in."

The APPG report ran over eight evidence sessions and assayed the views of PCTs and GPs as well as the pharmacy hierarchy. However, nearly two years on, Dr Stoate says it's time for a sequel. "What we're now doing is looking at the implementation of the white paper. We're going to look at barriers and hear about PCTs who are engaging and those who are not engaging." The inquiry kicked off earlier this month and will run throughout 2009. It will be some double if the APPG can help implement as well as inspire a white paper.

But it is not only through official documents such as the white paper that political allies can help the sector. Dr Stoate says that behind the scenes discussions between MPs on the APPG and senior figures at the DH are equally valuable.

As an example, he recounts a recent discussion with pharmacy minister Phil Hope in which the possibility of pharmacy representation on PCT boards was discussed – something Mr Hope made a pledge to tackle in his speech at the PSNC conference in March. "There's one or two barriers but I'm sure it's going to happen in one form or another," Dr Stoate adds.

Such advances signify a sea-change in pharmacy's political profile, Dr Stoate remarks. "There's a huge amount of time for pharmacy in government. There are many MPs doing constituency visits to pharmacies...The government wants pharmacists to improve clinical care."

And, despite the historical animosities, Dr Stoate says GPs are also on side. "There's lots of examples of where it works well. Too often we focus on the negative. I'm amazed by the variety of services pharmacists offer. It's just not reached the mainstream consciousness of GPs yet."

He argues that doctors dismiss the expertise of the local pharmacist at their peril. "During my time as a GP they've saved my bacon. Pharmacists have quite rightly picked up the phone upon reading a prescription and said: 'Did you really mean that?'. Every GP has been there."

The two professions have a symbiotic relationship and they're going to need each other more than ever in the future, Dr Stoate adds. While this transition will work better in some places than in others, he predicts that screening for chronic conditions, health MOTs and medicine use reviews are all prime contenders for areas of increased collaboration. "The government is working with GPs to take more and more work out of hospitals. Doctors will be doing more and have to pass some of their current jobs to others – a big chunk can go to pharmacy."

Overall, Dr Stoate forecasts that pharmacists have much to smile about both today and in the days ahead. "I'm really of the opinion that the age of pharmacy is with us. The profession is making a really huge contribution to healthcare and is on the cusp of a big thing."

One thing's for sure, you can guarantee that Dr Stoate will be providing more than a gentle nudge to help pharmacy get there.

Doctor's surgery

HOWARD STOATE ON...

How to make friends with your GP
"Pick up the phone and talk to them about the services you can help provide, it just needs someone to break the ice."

How to tactfully tell the GP he's got a prescription wrong
"If the pharmacist was to phone up and say 'you're poisoning patients' that would not go down well. However, if you said 'did you know Mrs Smith is already taking x,y and z?', most GPs would think 'thank God for that'."

If he's such a big pharmacy fan why didn't he train as a pharmacist?
"To be honest I'm not a brilliant businessman. I think pharmacists have to have that ability, which I lack."

Two blinded in acid attack

Mukesh Waghela rushed to hospital

Imagine the horror of being attacked late at night outside your pharmacy. Your eyesight is affected by what could be acid. This is Mukesh Waghela's story. He talks to **Chris Chapman**

All in the line of duty

Mukesh Waghela stands in his kitchen, gazing out at a world he is denied. "It's a beautiful day, but I can't go outside," he says, clutching a piece of tissue to a seeping burn that runs down the right side of his face. "I haven't been outside in three weeks, except to go to hospital."

Mr Waghela has been a prisoner in his own home since he was attacked on March 30. As he shut Wagpharm Pharmacy in Stratford, London, he and 17-year-old assistant Jilan Miah were assaulted in the alley behind the premises.

Two men loomed out of the shadows, armed with a colourless liquid in a plastic bottle. Without warning they sprayed the substance into Mr Miah's face. Before Mr Waghela could react, one of the robbers tried to squirt the liquid into his eyes. He was kicked to the ground, where the assailant rifled Mr Waghela's pockets before fleeing.

As Mr Waghela stumbled to his feet, he found his view of the world had become a cloudy blur. He could hear Mr Miah's cries for help but, with growing horror, realised he couldn't see properly.

"The best way to describe it is if you can imagine when it's foggy. It was just like that. It was foggy, and basically very sore."

The colourless liquid had left Mr Waghela and Mr Miah partially blinded, with burns to their faces. The pair were rushed to Newham General Hospital, before being transferred to Moorfields Eye Hospital. It was the first of many outpatient visits to eye clinics and burns units.

Meanwhile, the robbers were assessing their haul: £180, a few boxes of ibuprofen and some Jelonet dressings.

For a month after the attack, Mr Waghela's facial injuries needed to be washed three times a day, causing the wound to reopen and bleed.

"You think about not being able to work. If your eyesight is affected there are other consequences. You can't drive. It's been traumatic.

"And I feel guilty. I'm sitting here helpless and my family is running the shop. I should be doing the work, they should be taking it easy."

It is testament to Mr Waghela's selfless character that his first thoughts turn to his family, and the impact the incident has had on them.

However, he takes strength from the wealth of support he has received. Local surgeries have sent flowers; he has been visited by local GPs, PCT executives and his MP; and received messages of support from as far away as India and Australia.

"It's very touching. You don't think that so many people are going to ring, but the support has been overwhelming. The customers literally... some are crying at the shop. The support I've had is excellent, I can't expect any more from anyone."

But no declaration of support can dispel Mr Waghela's fears. His shop has been targeted repeatedly. Three years ago, after being held up at gunpoint, he wrote to his MP and the RPSGB, calling for heightened security. In the end, he says, the matter "fizzled out". There wasn't enough funding available to protect him.

"You shouldn't have to be working in fear," he says. "I think PCTs and the government should provide the same level of safety for all healthcare professionals, wherever they work... just because you happen to be a contractor, it doesn't mean you should be given any less degree of safety."

The Society agrees. David Pruce, director of policy and communications, told C+D that assaults were always unacceptable.

> "THE ROBBERS GOT AWAY WITH JUST £180, A FEW BOXES OF IBUPROFEN AND SOME DRESSINGS"

He says: "Assaults of any kind, verbal or physical, on pharmacists and their staff are totally unacceptable. People should be able to go about their working lives without fear of assault."

Mr Pruce said the new professional leadership body would look to address patient safety issues.

The charity Pharmacist Support (0808 168 2233) could also provide support and guidance for victims of crime, added Mr Pruce.

While the issue of security lingers, Mr Waghela doesn't know if he can remain in the profession. His eyesight has almost recovered, but he still occasionally experiences pain and haziness. Tests at Moorfields show his right eye is still inflamed.

His facial injuries are healing but remain severe and have now developed into a raised mass of scar tissue. Mr Miah's condition has also improved and he has been discharged from outpatients at Moorfields.

"His skin is healing but it will probably take some time before the skin reverts to normal," Mr Waghela said. "We don't know about scarring... The doctors said they'd only be able to tell you about scarring once the skin is healed."

And yet the worst scars are not physical; the true legacy of the ordeal is the myriad of fears that prey on Mr Waghela's mind.

"In the short term I'd like to get my life back to having a normal routine. As far as pharmacy goes, I don't know yet. Ideally I'd like to carry on, I don't like to let my customers down and I'll try and hold out as long as possible... but if something happens to me, I'll just have to ask them to forgive me."

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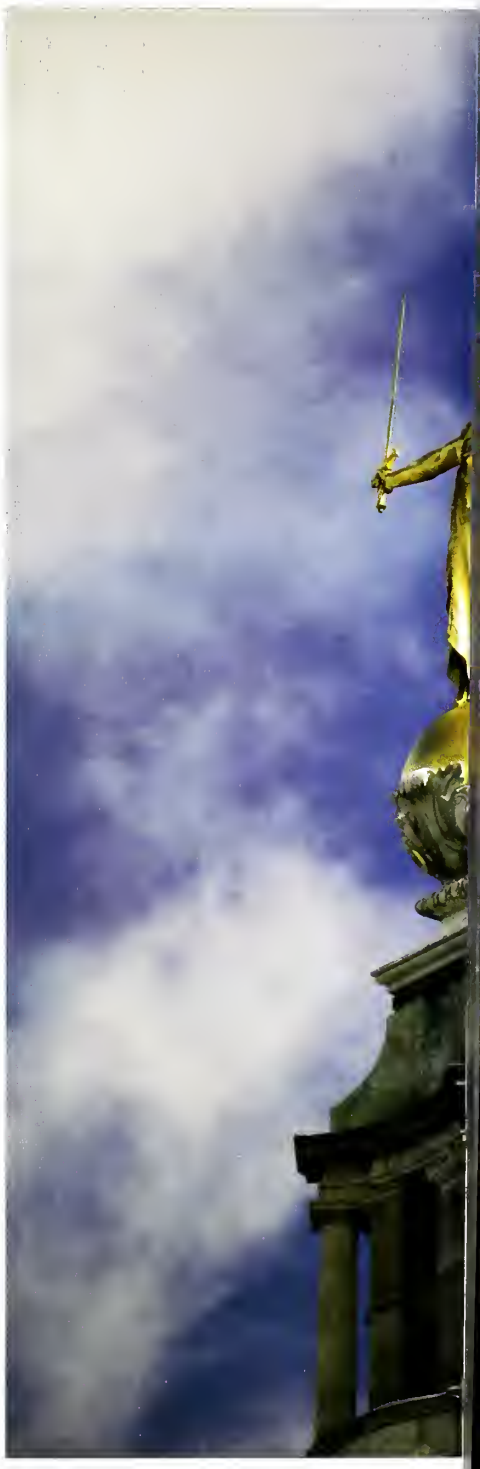
9LVN04 Date of preparation: April 2009

The Pharmacists' Defence Association unveils its campaign to prevent pharmacists being prosecuted for dispensing errors. Chairman **Mark Koziol** explains how your input can help secure its success

Chasing JUSTICE



Everybody makes mistakes: the age-old comfort so often offered when somebody has done something they later regret. And it's true. But not everybody faces criminal prosecution for their errors.

However, that's exactly what happened in the case of locum Elizabeth Lee, last month handed a suspended prison sentence for a single, one-off dispensing error that any practising pharmacist could have made. There but for the grace of God go I, must have been the first thought of most in the profession when they heard the news.

But while many – if not all – pharmacists are likely to make a dispensing error at some point during their careers (20,000 are made in England and Wales every month), the PDA believes it shouldn't take the grace of God, or any other divine power, to prevent them being criminalised. What's needed is a change in the law and its interpretation.

So the PDA has launched a campaign that aims to overturn Mrs Lee's conviction and ensure that no pharmacist in the future will have to go through her ordeal.

What happened to Mrs Lee?

On September 5, 2007, three days after the death of the patient (for which Mrs Lee was later found to bear no responsibility), Mrs Lee went to Maidenhead police station to answer questions. She was arrested on suspicion of gross negligence manslaughter and questioned at length.

She was interviewed on film, fingerprinted, photographed and a sample of her DNA was taken. Her house was searched and, after six and a half hours, she was released on police bail.

Over the following nine months Mrs Lee had to attend the police station four times to extend her bail until, finally, she was formally charged for two counts under the Medicines Act 1968.

Mrs Lee had to attend two Magistrates and two Crown Court hearings before eventually arriving at the Old Bailey on April 2 this year.

The police did not take any criminal action against Tesco Pharmacy, where Mrs Lee was working when the error occured, or any of its employees.

What happens in other health professions?

No one would disagree that if a healthcare professional's actions are criminally reckless and negligent, resulting in death, then they should face criminal proceedings.

However, with healthcare professions other than pharmacy, once a gross negligence manslaughter, assault or health and safety offence has been excluded, the criminal process ends there, with no criminal sanction taken for mistakes made in the workplace. Instead, there are professional disciplinary proceedings at the hands of the relevant regulator, and surely this is an appropriate outcome?

Clearly, the public deserves to know that if a pharmacist makes a mistake that harms them, then there should be redress. Such redress is rightly available to them in the form of civil proceedings for compensation and the knowledge that professional disciplinary proceedings will be taken.

Why must criminal proceedings for pharmacist workplace errors end?

The ability to make a professional judgment lies at the very heart of healthcare provision. The prospect of a criminal prosecution for making a mistake will be damaging to the public interest as few pharmacists will be keen to take a balanced risk in what they perceive to be in the interests of the patient.

Taking the criminality out of making mistakes in the workplace will not only be appropriate for pharmacists but will also be good for the public.

> THE CAMPAIGN AIMS TO OVERTURN MRS LEE'S CONVICTION AND ENSURE THAT NO PHARMACIST IN THE FUTURE WILL HAVE TO GO THROUGH HER ORDEAL

So what next?

The PDA has launched a campaign to decriminalise dispensing errors. It has set out two important objectives that need to be achieved.

The first is to overturn the conviction of Mrs Lee. The PDA intends to seek a more favourable interpretation of the 1968 Medicines Act, ideally in a higher court.

The association believes the Act was not designed to deal with dispensing errors made by pharmacists. If it can be shown that the 1968 Medicines Act was not an appropriate legal tool in the case of Mrs Lee, then this will be welcome news.

The second aim is to ensure that no pharmacist will ever have to face criminal prosecution in the future for making a mistake in the workplace.

We believe the long-term aim must be to ensure that where serious mistakes in the workplace involving pharmacists have occurred, professional regulation should be relied upon and not criminal process. The newly modernised pharmacist regulatory system means that the public interest would be very well protected by such an approach.

While the Medicines Act may not be appropriate for dispensing errors in the pharmacy setting, it is still generally appropriate for many wider medicines related matters and as such is relied upon by the Medicines and Healthcare products Regulatory Authority (MHRA) to regulate the activities of medicines manufacturers.

The PDA believes that to avoid any future doubt, limited changes to the Medicines Act should be made as soon as possible to ensure there can be no criminal prosecutions for genuine errors made by pharmacists in the workplace. Such an arrangement would also put pharmacy on a level playing field with other healthcare professions.

It will be of critical importance to ensure that the police are no longer involved in 1968 Medicines Act prosecutions in the future and that any action against either manufacturers or pharmacists is taken by the appropriate regulatory authority, whether the MHRA or RPSGB. This should mean professional disciplinary action and not criminal prosecution in the case of serious dispensing errors by pharmacists

How are we going to do this?

- Use the judicial process to secure an interpretation of the 1968 Medicines Act, which will place a question mark on the conviction of Mrs Lee.
- Use the parliamentary process to ensure that the1968 Medicines Act is amended urgently to clarify that it is not designed to deal with errors made by pharmacists in the workplace.
- Lobby the government to ensure that only matters of a truly criminal nature are handled by the police. All other matters should be passed to the pharmacist regulator so that a much more appropriate outcome can be achieved.

How can I help?

1. Contribute to the fighting fund. This campaign will require financial support if it is to be successful. Already, hundreds of pharmacists have made a contribution; the PDA asks that you make yours online via www.the-pda.org

2. Watch out for campaign announcements in the pharmaceutical press and mailings from the PDA.

3. Support the online petition for decriminalisation of dispensing errors, as this will be used in parliament and elsewhere. www.gopetition.com/petitions/decriminalisation-of-dispensing-errors.html

4. Attend the emergency meeting to be held on June 7 at the School of Pharmacy, University of London. To register visit www.the-pda.org

The PDA believes that by working together we can ensure that no pharmacist will in the future have to face the same experience as Mrs Lee.

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GENUS PHARMACEUTICALS

Boost your CV

Cinema addict or sports fanatic: **Chris Chapman** reveals which extracurricular interests will give your job application the edge

Adding sport to your CV demonstrates good social skills, teamwork and planning

Do you like candlelit dinners, walks in the rain, watching old movies and slow dancing until sunrise? So do I, but none of the above will add anything to your CV.

Your CV is not a personal ad. It's a sales pitch, selling you. You need to grab attention, demonstrate talent and say as much as you can about your value to an employer in a limited amount of space.

That said, you're not a list of previous jobs, or even the valuable skills you've gained in each position. You're a fully-rounded human being with a personality – and associated hobbies and interests – and you need to let that shine through in any job application. Picking the right extracurricular activities to mention can elevate your CV from the crowd.

David Standerwick, head of professional people strategy and implementation at Boots, knows how hard this can be. "Quite often, people will tell us they like walking, which is nice, or that they like to go to the cinema," he says. "Well, that's super, but it doesn't really help us in determining if that person's got a focus on customers and patients, which is what we're looking for."

You should always prioritise hobbies that show you go the extra mile. "The kind of thing we're looking for is voluntary work, such as working over the summer with Barnardo's, which demonstrates a predisposition to customer care and service," Mr Standerwick says.

Involvement with sports teams and community groups are a positive. These not only show that you have good social skills, but will emphasise teamwork and good planning and co-ordination.

A commitment to organisations such as the Scouts or Guides is also interesting to employers, especially as this will often involve organising groups that can be difficult to manage, such as children. However, these are only relevant if they are recent or you were involved for a long time.

"If [a candidate] got a 'rubbing sticks together' badge when they were 12, that's less interesting," explains Mr Standerwick. "But if they've stuck with it, that's interesting to employers."

So how far back should you go? Mr Standerwick says that activities as long ago as university can be noteworthy, especially if you held office.

Languages are important to mention, and those native to UK ethnic populations such as Urdu and Chinese may be looked on more favourably than French, German or Spanish. However, don't be disheartened if you can only speak English, you won't necessarily lose out. And it's always better to be honest about your ability, rather than say you can speak a language when your abilities are limited to asking for directions.

It's also worth setting down any effort you've taken to explore your career options, including time in hospital or industrial pharmacy. What works really well on a CV, Mr Standerwick says, is when a candidate shows he or she "has really thought about what they want from a career, what would be a good launch pad for it, and they've gone and done it".

Additional qualifications always add another string to your bow. Make sure you mention if you have a business degree, such as an MBA, or taken any courses that have provided you with a certificate. These again show commitment and a willingness to take proactive steps to develop skills and further your career.

You should also look to include qualifications gained during hobbies. For example, many voluntary medical organisations allow you to take first aid certificates, and scuba divers may gain training in search and rescue and resuscitation.

Ultimately, there are no hard and fast rules about which extra activities you include on your CV. But what's important is to stand back and consider what the line says about you as a person.

If it indicates teamwork, organisational skills, commitment, planning or any other qualities desirable by an employer, it could be the eye-catching line that makes you stand out from the crowd.

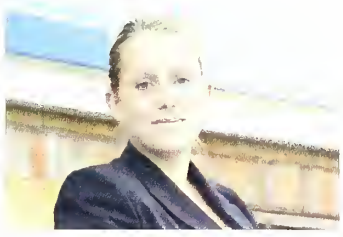
Career tip of the week

'Never stand still. Doing the job isn't the end [illegible] merely amounts to the end. And the end for you is promotion, [illegible] and experience to set out on your own [illegible] have to do the work. And yes, you have to [illegible] already be on the next step [illegible]

Your questions answered

I am failing to meet my MUR targets. What should I do about it?

Numark training manager Jane Lumb responds:



You say that you are failing to meet your MUR targets – well, the first thing to do is examine just how realistic those targets are! Targets are great at keeping you focused on delivering objectives, but they need to be realistic and achievable.

Think SMART:

Specific – what exactly are you trying to achieve?

Measurable – how will you determine success?

Achievable – are you able to meet this target?

Realistic/relevant – is the target reasonable and does it add value?

Timed – when are you going to do this by?

If a target is unrealistic we automatically switch off and don't really try, so start by breaking down what you want to achieve into manageable chunks. Perhaps your team can help you and suggest ways they can help recruit patients for the service?

Getting your team involved and working towards a shared goal will always help – do they understand just how important MURs are to your pharmacy?

Try to put a value on an MUR in terms they understand. For example, ask what would they rather do: recruit one patient for an MUR or trade up 100 customers to buying a pack of tissues?

Talk to your staff about what is important to you and why, and you will find that they will be keen to help you achieve your goals. Ignore them as simply someone that sells products or gives out prescriptions at your peril! Counter staff should be recognised as an integral part of your team, so let them help.

C+D

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You will also analyse prescribing data in support of the Head of Medicines Management. You should have substantial post qualification experience, have excellent communication skills and be a car driver/owner (subject to the provisions of the Disability Discrimination Act 1995 and 2005).

For further information please contact Mark Galloway, Head of Medicines Management, Christchurch House, Greyfriars Lane, Coventry CV1 2GQ. Telephone 024 7624 6105.

For the most efficient way to apply for this post please go to www.jobs.nhs.uk and search under Coventry, the POST REF is 785-PCC-SP-03. Applications are automatically forwarded to the recruitment team from the website.

Closing date: 6 June 2009.

For more information/details about the vacancy please visit our website: www.jobs.nhs.uk/in/coventryteachingpct

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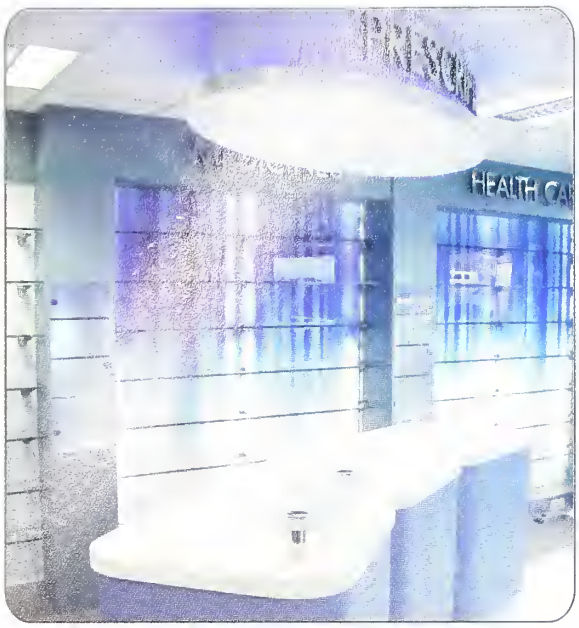

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Postscript...

Mike Hewitson's diary of a new pharmacy owner

Shouldering responsibility

When I was an employee, taking time off was so easy – just book a locum and take a week off. Now I'm self-employed and have to pay for the locum myself, I've either got to really want a day off or I have to have a very good excuse!

The local surgeries run a carers support group to help both carers and carees, and they normally have a speaker come to their meetings to try to provide them with advice and support for what is a vital but under-recognised role.

I volunteered myself to talk on the subject of 'medication'. By keeping the title as vague as I could meant, in my head at least, little or no prep work. I also figured that it would be a good excuse to take the rest of the day off to spend with my family.

My aim for the meeting was to try to establish what issues carers face with medicines, to signpost the variety of help that is available, such as our collection and delivery service, and to provide a point of contact with any medicines related questions.

The group was about 25-strong, and seemed receptive to pharmacy, even though a large proportion were dispensing patients for the surgeries. The event was definitely worthwhile because it gave carers in the town a lot of opportunity to ask questions – and I was able to promote MURs and services, so I think we both benefited.

It was only afterwards that I discovered I'd spent the whole day dishing out this sound advice with baby vomit on my shirt...

> KEEPING THE TITLE AS VAGUE AS POSSIBLE MEANT, IN MY HEAD AT LEAST, LITTLE OR NO PREP WORK

Raiders of the lost archives

C+D 1859-2009 Celebrating 150 years in pharmacy

Tarnished honour, demands for satisfaction and pistols at dawn were the order of the day in Victorian Cornwall, according to the January 1860 issue of Chemist & Druggist.

In what was described as "a laughable affair", the son of a pharmacist and the son of a "retired gentleman" in West Cornwall, fought a duel over a local girl who'd caught their eye.

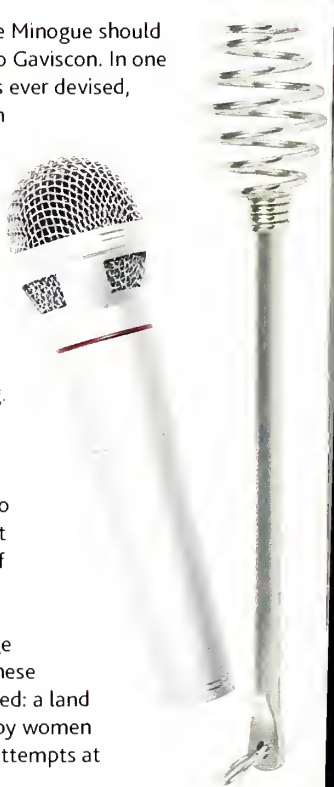
According to C+D, neither of the frisky Romeos was willing to back down and take a cold bath, leaving the two dopes with no option but to try and blow the other's head off. Or, at least, pretend to try.

"They fired two rounds each," reported C+D, "neither wishing to hit the other, because they regarded their own lives better than to give them up for the person they were fighting for."

And they say romance is dead...

Gordon and Kylie, sitting in a tree...

Gordon Ramsay and Kylie Minogue should get together, according to Gaviscon. In one of the most tenuous links ever devised, the heartburn medication decided to celebrate its Double Action formula by working out which celebrity couple would be the most powerful if brought together. The Gaviscon team put a lot of effort into it. They had equations and everything.



Inexplicably, chef Ramsey and pint-sized Antipodean popstar Kylie topped the bill, as the duo that would have the most "influence on the public if brought together".

Postscript shudders at the thought of the strange post-apocalyptic world these two would rule if combined: a land of foul-mouthed tirades by women in hotpants and terrible attempts at acting by ex-footballers.

Wait a moment...

No sex please, we're Chinese

If you were planning to visit China's first safe-sex theme park, you're in for a disappointment: the Chinese government has sent in the bulldozers before it could even open its gates.

Love Land, which was due to open in Chongqing, was to have offered workshops on safe sex and AIDS, but the Chinese government has torn down the park, with officials reportedly describing it as "ill-minded".

Park manager Lu Xiaoqing had said the park was "for the good of the public", telling the Chinese state newspaper China Daily he would "pay attention and not make the park look vulgar and nasty".

The entrance featured a giant rotating statue of a man in briefs, and the main attraction would have been a giant replica genital mounted on a wall.

Sounds tasteful enough to us...

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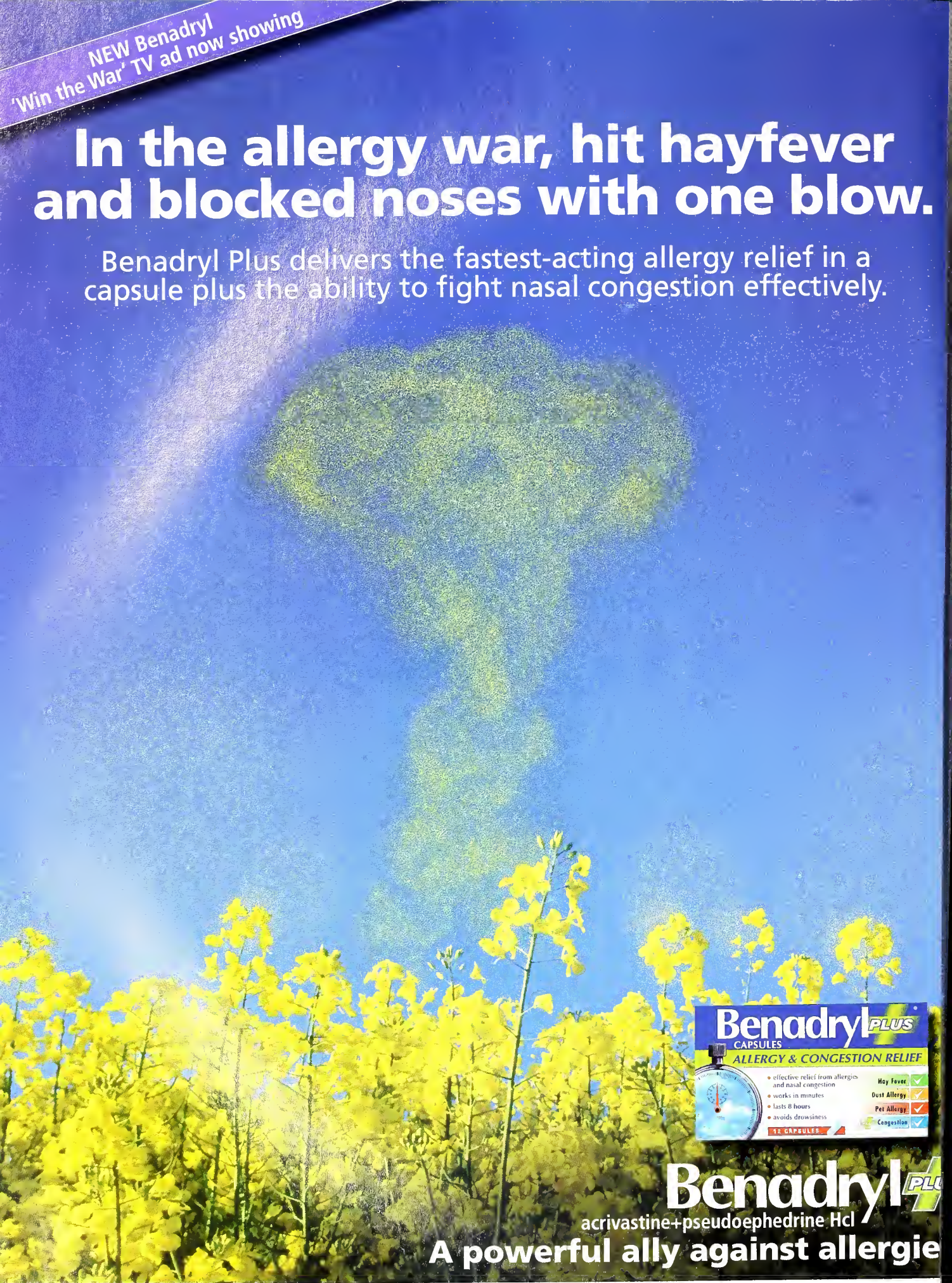

Benadryl Plus Capsules Product Information: Presentation: Acrivastine 8mg and pseudoephedrine 60mg capsules. **Uses:** Symptomatic relief of allergic rhinitis **Dosage:** Adults and children 12 - 65 years: One capsule as necessary, up to three times a day. **Contraindications:** Hypersensitivity or intolerance to any of the ingredients or triprolidine. Severe hypertension, severe heart disease or significant renal impairment; patients who have taken MAOI's in the preceding 14 days. Concomitant use with furazolidone. **Precautions:** Diabetes, hyperthyroidism, heart disease, hypertension, glaucoma or prostatic enlargement. Advise patients not to undertake tasks requiring mental alertness whilst under the influence of alcohol or other CNS depressants. Effects of alcohol or other CNS depressants may be enhanced. Patients taking sympathomimetics, antihypertensives, and tricyclic antidepressants. **Pregnancy & lactation:** Not recommended. **Side effects:** Ra drowsiness, CNS excitement, occasionally skin rash, or urinary retentio men. **RRP (ex-VAT):** 12s £4.99. **Legal category:** P. **PL holder:** Mc Products Ltd, Foundation Park, Maidenhead, Berks, SL6 3UG. **PL number:** 15513/0017. **Date of preparation:** April 2008

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